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Robert D. Hinshelwood

ABSTRACT

In this paper I examine one way in which psychoanalysis could contribute a natural ethics based on the inherent psychological development of a moral conscience. Psychoanalytic object-relations theories postulate the fundamental relational nature of human beings, and therefore the correlated concerns about the well-being of others. The notion of unconscious projective identification central to some theories provides an ethic of integration.

KEYWORDS

Natural ethics; Splitting; Ethic of integration; Consent

Ética natural e consentimento livre e esclarecido

RESUMO

Nesse artigo eu examino uma forma através da qual a psicanálise poderia contribuir com uma ética natural baseada no desenvolvimento psicológico inerente à consciência moral. As teorias psicanalíticas das relações de objeto postulam a fundamental natureza relacional dos seres humanos e, por conseguinte, sua correlata preocupação com o bem-estar dos outros. A noção de identificação projetiva inconsciente, central em algumas teorias, oferece uma ética de integração.

PALAVRAS-CHAVE

Ética natural; Splitting; Ética de integração; Consentimento

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Freud (1921a) was unimpressed with Putnam's attempts (PUTNAM, 1921) to tie psychoanalytic evidence to a strict sexual morality. He was scathing of ethical principles based on religious belief (FREUD, 1930). He expressed doubt

> as to which of the countless philosophical systems should be accepted, since they all seemed to rest on an equally insecure basis, and … [wished] to wait, and to discover whether a particular attitude towards life might be forced upon us with all the weight of necessity by analytical investigation itself (FREUD, 1921a, p. 270)

As an experimental psychology, psychoanalysis, he believed, shared a 'weltanshauung' with natural science (FREUD, 1933). He thought there was, to date, no 'natural' ethics, which could be grounded in the nature of human beings; and if there was to be one it would emerge from psychoanalysis. But he was ever hopeful that psychoanalysis would reform every branch of knowledge.

Natural ethics: Instead, Freud contented himself with what he thought of as a scientific investigation of, and data on, the ethical systems that operate within human beings (notably the super-ego). The theory of the super-ego is one which explains *how* people acquire ethical systems – not *which* ethical system they will acquire.

In the following, I briefly point to a way in which psychoanalysis can indicate '*which* ethical system'[1]. It is not in fact impossible for psychoanalysis to generate ethical principles. But that requires a little journey beyond Freud himself. One of the major developments in psychoanalytic ideas since Freud, has been the theories of 'object-relations'[2]. Those theories hold a promise for ethics in their fundamental notion that human beings seek others to relate to (FAIRBAIRN, 1952). Psychoanalytic work then involves investigation of human relations, and their development from 'immature' forms to 'maturity'. This model has the opportunity then to describe ethical relations as psychologically mature ones – or to put it

[1]Expanded in *Therapy of Coercion: Does Psychoanalysis Differ from Coercion* (HINSHELWOOD, 1997).
[2]In this brief paper I will concern myself largely with the theories of Melanie Klein, rather than for instance Winnicott and Balint, and the recent American inter-subjectivist schools, as well as the ethical investigations of Lacan.

succinctly, ethical relations are 'healthy' relations. Right actions towards other people can be described in terms of psychologically mature relations.

Much is begged in this assertion. For instance, one possible charge against this psychologising of ethics is that an object-relations view of maturity is itself based on current ethical principles, leading to a circular argument. However this is not so, as object relations psychoanalysis does not simply endorse current ethical principles. Instead it goes beyond them and comes to novel judgements about ethical principles. It does so in the following way.

Our cultural expectations (since Mill 1859) increasingly require ethical judgements of right behaviour towards each other to conform to the principle of allowing each other maximum freedom – known as autonomy.

In fact, object-relations theories do not necessarily, and simply, reconfirm the pre-eminence of autonomy as the priority principle in ethics. Quite the contrary, object-relations theory as I have argued, (HINSHELWOOD, 1997) show the simple notion of autonomy to be inadequate. Holmes and Lindley (1998), for instance claim that "autonomy and dependence are not contradictory" (p. 6); and they are led to postulate a category they call 'emotional autonomy', and a mature form of dependence which is called interdependence by Winnicott (1971).

This argument from the work of object-relations psychoanalysts which undermines the ordinary view of autonomy, is joined by a much more serious problem with the ordinary meaning of 'freedom of choice'; and I shall concentrate on the latter below. Such psychoanalytic theories therefore call into question the contemporary socio-cultural requirement for autonomy. Then, since an object-relations ethics stems from observations of actual human relating, it could be deemed to present, or partially present, a naturalised form of ethics[3].

[3]Typically the naturalisation of knowledge (e.g. Spenserian sociology, or contemporary sociobiology) is to gain a 'value-free' perspective. To counter that, and to recover value in human affairs, it is necessary to lay bare the

Consent for treatment: What constitutes consent for treatment, and informed consent[4], is psychoanalytically a problem (Hinshelwood). Yet it is central to medical ethics, and the ethics of psychoanalysis tends to follow medicine in this respect. Conventionally, the ethical injunction runs thus: the patient is entitled to be informed fully of the nature of a treatment offered and its consequences. Then, armed with this knowledge he decides to have the treatment, or not, a decision that is made in conjunction with a doctor who is willing to prescribe the treatment (GILLON, 1986).

One problem in practice is that the amount of intelligible information a patient can grasp (unless medically trained him/herself) will be limited. But, more interesting for ethicists, the notion of consent implies a capacity in the patient for rational thought. It is clear that not all patients are so capable, and those include a large category of psychiatric patients (although it also includes, people with organic dementias, brain damage, drug intoxication, etc.). It turns out that the notion of autonomy, and of consent for treatment which rests on autonomy, is conditional upon the key assessment of the level of rationality – or of irrationality as some insist (CULVER; GERT, 1982). So, it is clear that in this respect, the important ethical principle (autonomy) rests on a certain level of normal psychological functioning.

These problems are normally manageable in a professional practice. However, it is also true that particularly psychoanalysis has taken on the understanding of irrationality, and has established that irrationality is a fundamental aspect of human mental functioning (see, for instance, Lear's account of Freud's case of the Ratman, Chapter 5 in Lear 1998). Freud called it the primary process[5] in which time and the ordinary rules of reasoning do not apply, it forms a non-logical thinking which underlies all higher mental function. Hence the test of rationality (or irrationality) is suspect.

hidden values that are employed in various natural science projects (see for instance the Journal *Science as Culture*). However this present argument is a strategy that naturalise ethics, and thus places value within the natural world.

[4]This was the starting point for my earlier investigations (HINSHELWOOD, 1997).

[5]Basic psychoanalytic concepts can be clarified by reference to Sandler, Dare and Holder (1973)

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Individuality and the divided mind: More than this there is a problem in the whole conception of the individual. If our culture tends to promote the idea of a single discrete and bounded individual, who is the locus of autonomous decisions. But, it is difficult to sustain that ideal, when considering people in actuality. Feud quoted LeBon (1895) to the effect that

> Whoever be the individuals that compose [the group], however like or unlike be their mode of life, their occupations, their character, or their intelligence, the fact that they have been transformed into a group puts them in possession of a sort of collective mind which makes them feel, think, and act in a manner quite different from that in which each individual of them would feel, think, and act were he in a state of isolation (quoted in FREUD, 1921b, p. 73).

Though LeBon was writing about a crowd, without organisation, Freud went on to discuss similar alterations of the individual in the smallest of all groups, the couple. He described the changes that occur in character when a person is under a trance with a hypnotist, when the capacity for personal independence and choice may be given over almost completely to the hypnotist. Freud also considered the state of mind of when a person is in love who has a vary distorted view of reality (notably the loved one); and he related these alterations in the individual's freedom and sense of reality to what is known about the analyst and analysand couple.

Freud, in fact, has been responsible for a major incursion into the idea of the indivisible individual. He described the division of the mind into conscious and unconscious, and how those parts of the mind work against each other (DILMAN, 1984). This, the deepest layer of mental conflict, means that the choice involved in consent for treatment (as, in fact, all choices) is not simply at the conscious level of the pros and cons which the doctor will have explained to the patient.

This unconscious component is never more clear than in the choice to consent to a psychoanalytic treatment. In their book on the values of psychotherapy, Holmes and Lindley (1998) asserted that "Co-operation is the essence of psychotherapy" (p. xvii); and so it is, a psychoanalysis cannot proceed except on the basis of the voluntary agreement of the patient. But that is only part of the story, since, as soon as a psychoanalytic treatment starts, the patient shows 'resistances'. They are, by and large, from the 'unconscious', resistance sits side by side with the patient's conscious belief recognition of the benefits of a psychoanalysis.

The patient is not of one mind. Nor is he properly aware of the conflict in himself if one side of the conflict is unconscious. So, if some of his motivation is unconscious, he cannot make a conscious and autonomous choice from the alternatives. This poses a real problem to the notion of autonomy as ordinarily understood (LINDLEY, 1986).

Splitting: The matter worsens with Freud's descriptions, late in his career, of splitting of the ego (FREUD, 1940). In that instance there is not even a conflict between the conscious and unconscious minds. The split off part of the mind is no longer part of the organised whole. Melanie Klein advanced the descriptions of this splitting of the mind, showing that in many instances the split-off part of the mind could be transferred into, felt as part of another mind; that is, as part of the mind of another person. For instance, a man with a particularly macho self-image may be unduly hostile to those he regards as gay because of his fear of his own affection for men; they are in effect hostile to that affectionate part of themselves, *seen as* the other[6]. This is known as projective identification (KLEIN, 1946). Then that part projected into the other, may be actually 'owned' by that receiving other (SANDLER, 1976; see HINSHELWOOD, 1997, Chapters 5, 6, and 7, for illustrations of this peculiar unconscious phenomenon). The result is a conflict in which the patient is antipathetic to his psychoanalytic treatment (known as a negative transference) whilst and the analyst who holds the positive motivation for both of them, continues to persuade the patient of the benefits of psychoanalysis.

[6]Another instance might be how Hitler's own violent ambitions to take over the world was seen by him as *in* the Jews and as their conspiracy for world domination; he could then attempt to exterminate it, *in them*.

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In other medical treatments, too, responsibility is passed over to staff from patient's who might more rationally retained it:

> The hospital, particularly the nurses, must allow the projection into them of such feelings as depression and anxiety, fear of the patient and his illness, disgust at the illness and necessary nursing tasks. Patients and relatives treat the staff in such a way as to ensure that the nurses experience these feelings instead of – or partly instead of – themselves: for example by refusing or trying to refuse to participate in important decisions about the patient and so forcing responsibility and anxiety back on the hospital. Thus to the nurses' own deep and intense anxieties are psychically added those of other people concerned (MENZIES, 1959, p. 49).

This describes a redistribution of responsibility in a general hospital with ordinary, mentally healthy patients and staff. Similarly, Conran (1985) also saw a redistribution of responsibility into hospital staff occurring with mentally healthy patients as well as psychotic ones. He elegantly described its location in a case of appendicitis and one of manic-depression. These empirical observations confirm the general point that human personalities can be divided and redistributed within the social field. The problem is general for the professions and in psychoanalytic treatments.

Practice and integration: Given the fact that people are not of one mind, and that mental parts are 'socially mobile', the problem of personal autonomy increases. If the analyst, for a while, represents, and in an existential sense, *is* the patient's consent for treatment, we cannot rely on the simple tests of rationality and autonomy to decide on ethical practice. There is a real problem: Whose consent for treatment.

In psychoanalytic work, we actually investigate these irrational disruptions, not merely disruptions to reasoning, but to individuality, autonomy and decision-making. Thus a projection of responsibility or motivation into the analyst can confuse the genuine autonomy of either partner. This level of human relating is normally beneath consciousness. Since ethics is the prescription of right forms of relating, it cannot ignore these problems revealed by psychoanalysis.

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Autonomy is therefore a subverted principle because decision-making capacities of the individual have been separated and redistributed though the interpersonal field of others. In the light of this degradation of autonomy the nature of ethical action can be recast as the degree to which one person will enhance or reverse splitting processes. We can therefore define this as a *principle of integration*. This does not completely replace the principle of autonomy, since integration (or the integrity of the person, in this sense) underlies autonomy, and makes it a secondary or derivative consequence of integration.

At the same time the task of reversing those separations - or at the very least not enhancing them, is the activity of a psychoanalysis itself. We must, in an analysis, investigate the relational context in the work itself – the transference and countertransference, or the way that analyst and patient act upon each other. So, if ethics is the study of the right action of one person towards another, so is a psychoanalysis; and the ethics of psychoanalysis in a meaningful way becomes the psychoanalysis of ethics. The practice of psychoanalysis is simply the practice of ethics, and an ethical system becomes naturalised as the product of a scientific practice.

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